CDC
CENTERS FOR DISEASE CONTROL

January 24, 1992 / Vol. 41 / No. 3

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Health Objectives for the Nation

Vigorous Physical Activity Among High School Students – United States, 1990

Vigorous physical activity can improve the health of both adults and children. Among adults, regular physical activity can reduce risk for chronic diseases such as coronary heart disease, hypertension, noninsulin-dependent diabetes mellitus, colon cancer, and depression, as well as lower all-cause death rates (*1,2*). Among children, regular physical activity can reduce chronic disease risk factors such as obesity, elevated cholesterol, and hypertension (*3*). Physical activity patterns established during childhood may extend into adulthood (*4*). This report examines the prevalence of vigorous physical activity among U.S. students in grades 9–12.

The national school-based Youth Risk Behavior Survey (YRBS) is a component of the Youth Risk Behavior Surveillance System, which periodically measures the prevalence of priority health-risk behaviors among youth through representative national, state, and local surveys (*5*). The 1990 YRBS used a three-stage sample design to obtain a representative sample of 11,631 students in grades 9–12 in the 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands. Students were asked on how many of the 14 days preceding the survey they had had "at least 20 minutes of hard exercise that made you breathe heavily and made your heart beat fast." Students who reported having engaged in this kind of exercise 3 or more days per week were classified as vigorously active. Students also were asked if they had exercised in a sports league, dance class, recreational center, or any other community center during the 14 days preceding the survey; how many hours a day (on an average school day) they watched television and videos during the 14 days preceding the survey; and on how many varsity or junior varsity sports teams they played at school during the 12 months preceding the survey.

Of all students in grades 9–12, 37.0% reported being vigorously active three or more times per week (Table 1). Vigorous activity was significantly less common among female students (24.8%) than among male students (49.6%), among black students (29.2%) than among either white (39.3%) or Hispanic (34.5%) students, and among female students in grades 11 (23.4%) and 12 (17.3%) than among those in grade 9 (30.6%).

Physical Activity — Continued

For both sexes, students who were vigorously active were significantly more likely to participate on varsity or junior varsity sports teams and to exercise at a community center than were those who were not vigorously active (Table 2). Female students

TABLE 1. Percentage of high school students who participated in vigorous physical activity 3 or more days per week, by sex, race/ethnicity, and grade — United States, Youth Risk Behavior Survey, 1990*

	Female		Male		Total	
Category	%	(95% CI†)	%	(95% CI)	%	(95% CI)
Race/Ethnicity						
White	27.5	(±2.9)	51.4	(±2.7)	**39.3**	**(±2.7)**
Black	17.4	(±3.5)	42.7	(±6.7)	**29.2**	**(±4.3)**
Hispanic	20.9	(±4.5)	49.9	(±6.1)	**34.5**	**(±4.1)**
Grade						
9th	30.6	(±2.9)	51.1	(±5.1)	**40.1**	**(±3.7)**
10th	27.1	(±4.7)	54.6	(±4.1)	**40.7**	**(±3.5)**
11th	23.4	(±3.1)	50.2	(±3.9)	**36.0**	**(±3.3)**
12th	17.3	(±2.9)	43.8	(±6.1)	**31.7**	**(±4.1)**
Total	**24.8**	**(±2.4)**	**49.6**	**(±2.5)**	**37.0**	**(±2.4)**

*Unweighted sample size = 11,631 students.
†Confidence interval.

TABLE 2. Percentage of high school students who played on a varsity or junior varsity sports team, exercised at a community center, and watched television or videos, by sex and activity level — United States, Youth Risk Behavior Survey, 1990*

	Female				Male			
	Vigorously active†		Not vigorously active§		Vigorously active		Not vigorously active	
Category	%	(95% CI¶)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Played on ≥1 varsity or junior varsity sports teams**	54.7	(±6.3)	28.7	(±3.7)	63.7	(±4.3)	38.8	(±3.7)
Exercised at a community center ≥3 days per week††	26.7	(±3.5)	4.0	(±0.8)	26.6	(±3.1)	5.5	(±1.2)
Watched television or videos ≥3 hours per day††	32.5	(±4.3)	40.4	(±3.1)	35.8	(±2.7)	37.3	(±2.9)

*Unweighted sample size = 11,631 students.
†Students who engaged in at least 20 minutes of hard exercise that made them breathe heavily and their hearts beat fast 3 or more days per week.
§Students who engaged in at least 20 minutes of hard exercise that made them breathe heavily and their hearts beat fast fewer than 3 days per week.
¶Confidence interval.
**During the 12 months preceding the survey.
††During the 14 days preceding the survey.

Physical Activity — Continued

who were vigorously active were significantly less likely to watch television or videos 3 or more hours per day (32.5%) than were female students who were not vigorously active (40.4%).

Reported by: Div of Chronic Disease Control and Community Intervention, Div of Adolescent and School Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: A national health objective for the year 2000 (objective 1.4) is to increase to at least 75% the proportion of youth aged 6–17 years who engage in vigorous physical activity that promotes the development of cardiorespiratory fitness (i.e., 3 or more days per week for 20 or more minutes per occasion) (*6*). Data in this report indicate that current levels of vigorous physical activity among high school students will have to more than double to reach this objective.

Moreover, findings in this report suggest that participation in vigorous physical activity among high school students may be decreasing. The National Children and Youth Fitness Study conducted in 1984 showed that 61.7% of students in grades 10–12 participated in vigorous physical activity for 20 or more minutes 3 or more days per week (*7*); only 36.1% of students in grades 10–12 reported doing so in the current report. Participation in school physical education also may be decreasing (*8*).

Race/ethnicity- and sex-specific differences described in this report are consistent with patterns of physical activity observed among adults (*9*). Lower levels of physical activity characteristic of black adults and adult females of all races may be manifest by grade 9. Interventions to increase physical activity among persons in the United States need to target school-aged youth to help reverse declining levels of physical activity and break patterns of sedentary living. School physical education, sports teams, and community recreation centers should be used to help promote lifelong physical activity (*6,8*). Educators, families, physicians, and public health officials need to establish policies and programs that help increase access to physical activity facilities for youth and encourage youth to participate regularly in vigorous physical activity (*6*).

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Epidemiologic Notes and Reports

Bacterial Contamination of Platelet Pools — Ohio, 1991

From June 27 through July 30, 1991, four episodes of bacterial contamination of platelet pools occurred in an Ohio hospital and were reported by the hospital through the Food and Drug Administration (FDA) to CDC. This report summarizes the results of the epidemiologic investigation of these episodes.

Three of the four patients who received the platelet pools were hospitalized for malignancies and developed chills and rigors within 1–40 minutes after initiation of the transfusion; one of the three developed hypotension. After two of these episodes, the hospital began pretransfusion Gram staining and culturing of all platelets but did not delay platelet transfusion awaiting Gram stain or culture results. This increased surveillance detected a fourth contaminated platelet pool, but it had already been transfused to a hemodialysis patient with idiopathic thrombocytopenia associated with myelodysplasia; this patient developed asymptomatic bacteremia.

The FDA and CDC initiated an investigation to attempt to detect the source of and risk factors for contamination of these platelet pools. A contaminated platelet pool was defined as a platelet pool with a positive bacterial culture confirmed by either a positive Gram stain of the pool, a positive culture in an individual platelet unit that was part of the platelet pool, or a positive culture from blood obtained from the transfusion recipient from June 27 through July 31. The four contaminated platelet pools, each derived from five individual platelet units, were positive by Gram stain and culture for *Bacillus cereus* (two platelet pools) and *Staphylococcus epidermidis* and *Pseudomonas aeruginosa* (one platelet pool each); colony counts ranged from 10^6 to 10^8 colony-forming units (CFU) per mL in the platelet pools, and from 10 to 10^{10} CFU/mL among 11 of the 20 individual platelet units constituting the pools.

On average, the individual platelet units constituting the contaminated platelet pools were pooled 2.5 hours (range: 15 minutes–3.2 hours) before transfusion. Investigators examined data on the four contaminated platelet pools for associations with the phlebotomists, bloodmobile sites or dates, component separation technicians, pooling technician, pooling date and time, and platelet age. However, no units from any two pools shared any of these factors.

From June 27 through July 30, the rate of bacterial contamination of platelet pools at the hospital (four [0.4%] of 1063 platelet pools transfused) was significantly greater than for the previous 21 months (one [0.01%] of 7350 platelet pools transfused, $p=0.001$). During the 21 months before June 27, 1991 (when the hospital instituted more stringent guidelines for detection and reporting of platelet-transfusion reactions), the nursing staff at the hospital increasingly reported platelet-transfusion reactions to the hospital blood bank (99% of which resulted in culturing of the involved platelet pool). The rate of reported reactions, by month, increased from 2.3 per 1000 platelet pools transfused during September 1989 to 72.4 reported reactions per 1000 platelet pools transfused during July 1991 ($p<0.001$, chi-square for linear trend).

The hospital continues pretransfusion Gram staining and culturing of all platelets and now requires a negative Gram stain before releasing the platelets for transfusion.

Reported by: TJ Halpin, MD, State Epidemiologist, Ohio Dept of Health. S Kilker, Cincinnati District; J Epstein, MD, Div of Transfusion Science, M Tourault, Div of Inspection and Sur-

Contamination of Platelet Pools — Continued

veillance, Office of Compliance, Center for Biologics Evaluation and Research, Food and Drug Administration. Investigation and Prevention Br, Hospital Infections Program, National Center for Infectious Diseases, CDC.

Editorial Note: Platelets may be obtained from plasmapheresis or from whole blood donations; the latter are produced by a closed two-step centrifugation system within 8 hours of obtaining whole blood from the donor. Individual platelet units are then stored at room temperature for ≤5 days before being transfused or pooled with one to 10 other individual units (*1*); once pooled, the platelets must be transfused within 4–6 hours. During 1986, the FDA established the maximum storage time for platelets as 5 days (*2–4*).

In the United States, up to 10% of platelet pools used in transfusions may be contaminated, a potentially serious complication of platelet transfusion (*4*). Most episodes of bacterial contamination of platelets involve skin saprophytes such as *S. epidermidis* and *Bacillus* sp.

In this investigation, the findings of high colony counts in some individual platelet units suggest that the individual units were contaminated at the time of donation and that the contaminating organisms proliferated at room temperature during the interim between donation and pooling. Conversely, the short interval between pooling and transfusion was insufficient for bacteria to proliferate to the high colony counts present in the pooled platelets at the time of transfusion. The increased discovery of contaminated units at this hospital probably occurred because of rigorous reporting of platelet-transfusion reactions and the subsequent culturing of those platelets.

The findings in this investigation are consistent with those in a previous report in which six (<0.06%) of 10,219 platelet pools transfused were contaminated with bacteria (*5*). Both the hospital involved in that report and the hospital reported here had established protocols for intensive surveillance for platelet-transfusion reactions and routine culturing of those platelets associated with reactions. Hospitals that institute such measures will identify more units of bacterially contaminated platelets; CDC recommends that all platelets involved in transfusion reactions be evaluated for bacterial contamination to more accurately estimate the incidence of bacterial contamination of platelets. Clinicians and blood center personnel are requested to report all episodes of transfusion reactions related to bacterial contamination of platelets through state health departments to CDC's Investigation and Prevention Branch, Hospital Infections Program, National Center for Infectious Diseases; telephone (404) 639-1550. Fatal reactions to platelet transfusions must be reported to the FDA; telephone (301) 295-8191.

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Iguana-Associated Salmonellosis — Indiana, 1990

During 1990, the Indiana State Board of Health's Disease Control Laboratory reported isolates of a rare *Salmonella* serotype, *S. marina*, from two infants residing in different Indiana counties. This report summarizes epidemiologic and clinical information about these two cases.

Case 1

During August 1990, a low-birthweight newborn (2500 g) was discharged after 1 week of hospitalization. Five days after discharge, on a continuing diet of breast milk and iron-enriched formula, the infant developed watery diarrhea (20 stools per day) but had no fever. A stool culture obtained from the infant yielded *S. marina*, and therapy with oral antibiotics was initiated. The diarrhea resolved within 10 days; stool cultures remained positive for *S. marina* for 7 months. No *Salmonella* illness was recognized among the neonates or hospital staff on the ward on which the infant had resided. All household contacts of the infant were asymptomatic and had negative stool cultures for *Salmonella*. In addition, a culture of the household well water was negative for fecal coliforms and *Salmonella*.

The only indoor pet was an iguana that remained in a glass aquarium in the home. During April 1991, a stool culture obtained from the iguana was negative; however, two of nine cultures taken from the aquarium's surface yielded *S. marina*. Although the infant had no direct contact with the iguana or its environment, the infant's mother fed the iguana and cleaned its cage; she reported handwashing after these activities.

Case 2

During November 1990, a 3-month-old infant developed diarrhea and fever. Stool cultures obtained from the patient yielded *S. marina*. The infant was hospitalized for 6 days and treated with intravenous fluids and antibiotics; diarrhea persisted for 20 days. The infant was fed only powdered formula before onset of illness. Household contacts of the infant were asymptomatic, and stool cultures obtained from the contacts were negative for *Salmonella*; a culture of the household well water also was negative for *Salmonella*.

The only indoor pet was an iguana; during March 1991, the one stool culture obtained from it yielded *S. marina*. None of 10 cultures from surfaces in the cage yielded *Salmonella*. The iguana was confined to a wooden cage; the infant's father fed the iguana and cleaned the cage, and he reported handwashing after these activities. The mother and infant had no known contact with the iguana or its environment.

Investigation Findings

The two case-households were 80 miles apart, and the households' members had no known contact with each other. The *S. marina* isolates from the infants in both cases and from the iguana associated with case 2 had intermediate resistance to streptomycin but were sensitive to other routine antibiotics. No plasmids were detected in these isolates. The isolate from the cage of the iguana associated with case 1 was not available for testing. Both iguanas were purchased during the summer of 1989 from different pet stores; however, both stores received iguanas from the same distributor, who was supplied by one importer.

Salmonellosis — Continued

Reported by: B Barrett, K Khurana, MS, Disease Control Laboratory; JE Afanador, Acute Disease Div; ML Fleissner, DrPH, State Epidemiologist, Indiana State Board of Health. Div of Field Epidemiology, Epidemiology Program Office; Enteric Diseases Br, Div of Bacterial and Mycotic Diseases, National Center for Infectious Diseases, CDC.

Editorial Note: *S. marina* is an uncommon cause of human illness; it was first isolated in 1964 from a marine iguana (*1*). From 1979 through 1989, CDC received reports of only 18 human isolates of this serotype (*2*) and 28 nonhuman isolates in the United States. Of the 28 nonhuman isolates, 19 were from reptiles, and eight of those were from iguanas (CDC, unpublished data, 1991). The two cases reported here highlight the potential for salmonellosis to occur among persons exposed to pet iguanas. Infants are highly susceptible to *Salmonella* from any source. As with pet turtles, direct contact between the reptile and the infant does not seem to be necessary for transmission to occur.

Iguanas are members of the lizard family and are native to tropical areas in the Western Hemisphere. Lizards carry a wide variety of *Salmonella* serotypes, and the percentage of lizards harboring *Salmonella* species may range from 36% to 77% (*3–5*). Lizards have transmitted salmonellosis to humans (*3,6*), including transmission of *S. typhimurium* from a pet iguana to an infant by contaminated bathtub water (*7*).

Because iguanas from different countries are often shipped together in a single lot, and iguanas are not tagged during the shipping process, trace-backs are not possible. The exporting country issues a certificate of health for each lot of iguanas shipped, and no quarantine or health inspections are required for entry into the United States (U.S. Fish and Wildlife Service, unpublished data, 1991). Colonization with *Salmonella* may occur in the country of origin or following contact with other iguanas during shipping. Those colonized with *Salmonella* may shed organisms intermittently, and *Salmonella* may be present in the environment of an iguana even in the absence of positive stool cultures (*3*). Persons in contact with iguanas should practice strict handwashing after handling these animals or their environments, particularly in households with infants or elderly persons who may be highly susceptible to infection (*8*).

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Current Trends

Update: International Task Force for Disease Eradication, 1990 and 1991

In 1988, a decade after the successful eradication* of smallpox, the International Task Force for Disease Eradication (ITFDE) was formed to systematically evaluate the potential for global eradicability of candidate diseases, identify specific barriers to their eradication that might be surmountable, and promote eradication efforts. In its first two meetings in April and October 1989, the ITFDE determined that two of eight diseases examined were eradicable and three others were candidates for elimination of transmission or clinical symptoms (*1*). In its third and fourth meetings in August 1990 and June 1991, the ITFDE evaluated the potential eradicability of seven other diseases. This report summarizes the results of the third and fourth meetings.

The working criteria used by the ITFDE in evaluating the diseases evolved from formulations used in the first two meetings (see box). Based on these criteria, the ITFDE concluded that, of the seven diseases considered, mumps and rubella are potentially good candidates for eradication (Table 1).

Diseases Evaluated

Mumps. Mumps is probably eradicable through the use of measles-mumps-rubella (MMR) vaccine, but more data are needed documenting the impact of mumps and the use of the vaccine in developing countries. The necessary studies of mumps and rubella could be conducted simultaneously at the same sites.

*Eradication is defined as achievement of a status whereby no further cases of a disease occur anywhere, and continued control measures are unnecessary.

Criteria for Assessing Eradicability of Diseases

Scientific Feasibility

- Epidemiologic vulnerability (e.g., existence of nonhuman reservoir, ease of spread, natural cyclical decline in prevalence, naturally induced immunity, ease of diagnosis, duration of any relapse potential).
- Effective, practical intervention available (e.g., vaccine or other primary preventive, curative treatment, "vectoricide." Ideally, intervention should be effective, safe, inexpensive, long-lasting, and easily deployed).
- Demonstrated feasibility of elimination (e.g., documented elimination from island or other geographic unit).

Political Will/Popular Support

- Perceived burden of the disease (e.g., extent, deaths, other effects; true burden may not be perceived; the reverse of benefits expected to accrue from eradication; relevance to rich and poor countries).
- Expected cost of eradication (especially in relation to perceived burden from the disease).
- Synergy of attack with other interventions (potential for added benefits or savings, spin-off effects [e.g., polio eradication/Expanded Program on Immunization, guinea worm/Water and Sanitation Decade, yaws/Primary Health Care]).
- Necessity for eradication rather than control.

ITFDE — Continued

Rubella. Rubella is probably eradicable, but more data on this disease's impact in developing countries are needed to support development of the necessary political commitment to do so. Eradication appears economically feasible because of the combined MMR vaccine.

Hepatitis B. Although global eradication of hepatitis B is not now feasible, transmission can be eliminated over an extended period (i.e., decades) by universal vaccination.

Neonatal tetanus. Neonatal tetanus, a major cause of death in developing countries, is completely preventable and can be eliminated if effective interventions (e.g., aseptic deliveries and vaccination of mothers and children) are universally applied indefinitely; however, the disease cannot be eradicated.

Diphtheria. Diphtheria might eventually be eradicable; however, information regarding its effects in developing countries and the epidemiologic effects of widespread diphtheria vaccination in these areas is limited.

Pertussis. Pertussis is not now eradicable, but better control could be attained by improving the vaccine and diagnostic methods and by more thorough study of the

TABLE 1. Disease candidates for worldwide eradication — International Task Force for Disease Eradication, 1990 and 1991

Disease	Current annual toll worldwide	Chief obstacles to eradication	Conclusion
Mumps	Unknown	Lack of data on impact in developing countries; difficult diagnosis	Potentially eradicable
Rubella	Unknown	Lack of data on impact in developing countries; difficult diagnosis	Potentially eradicable
Hepatitis B	250,000 deaths	Carrier state, in utero infections not preventable; need routine infant vaccination	Not now eradicable, but could eliminate transmission over several decades
Neonatal tetanus	770,000 deaths	Inexhaustible environmental reservoir	Not now eradicable, but could prevent transmission
Diphtheria	Unknown	Difficult diagnosis; multiple dose vaccine; carrier state	Not now eradicable
Pertussis	60 million cases; 700,000 deaths	High infectiousness; early infections; multiple dose vaccine	Not now eradicable
Yellow fever	≥10,000 deaths	Sylvatic reservoir; heat-labile vaccine	Not now eradicable

ITFDE — Continued

disease's epidemiology in developing countries. If an appropriate antigen were available that could be administered safely to adults, studies should be conducted regarding the possibility of protecting infants better by booster vaccination of their mothers to enhance maternal antibody.

Yellow fever. Yellow fever is not eradicable because of the sylvatic cycle of infection. Nonetheless, better use of vaccine could eliminate yellow fever in urban areas and reduce epidemics in rural areas.

Other Diseases Discussed

In addition to evaluating the potential eradicability of these seven diseases, the ITFDE determined that an opportunity exists to greatly reduce the burden of disease caused by several major helminthic infections (e.g., schistosomiasis, ascariasis, hookworm disease, and trichuriasis) by using mass chemotherapy with appropriate combinations of broad-spectrum anthelminthics that are now available for oral administration in a single dose. The ITFDE endorsed an effort to undertake such a program in a developing country.

Reported by: DR Hopkins, MD, Global 2000, Inc, Carter Center of Emory Univ, Atlanta. K Warren, MD, Maxwell Communication Corporation, New York City. Div of Immunization, National Center for Prevention Svcs; Technical Support Div, International Health Program Office; Div of Viral and Rickettsial Diseases, Div of Vector-Borne Infectious Diseases, National Center for Infectious Diseases, CDC.

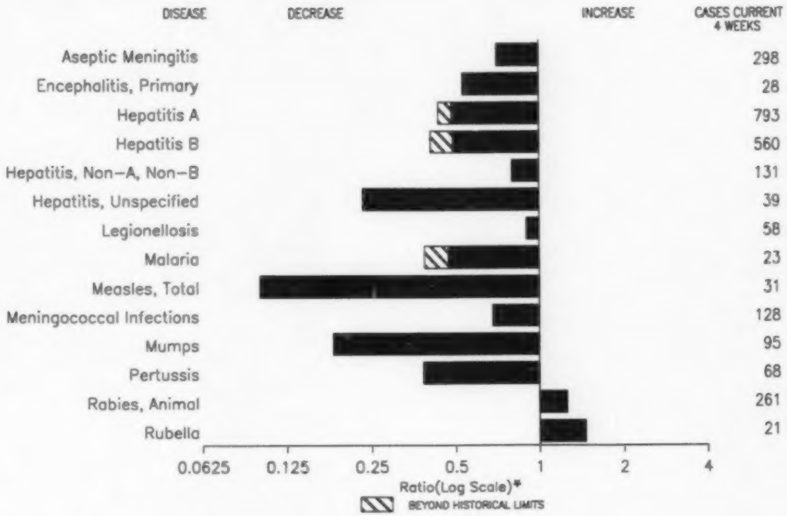
Editorial Note: At its first meeting, the ITFDE agreed on the eradicability of dracunculiasis and poliomyelitis, two diseases whose eradicability had been acknowledged previously by the World Health Organization. With its finding that rubella and mumps are also good potential candidates for global eradication, the ITFDE added a new element to the future international agenda for eradication. Appropriate agencies and other institutions should act promptly on the recommendation to seek more information about the impact of those two diseases (and of the respective vaccines) in developing countries.

In addition to adopting a resolution officially establishing the goal of eradicating dracunculiasis by the end of 1995, the 1991 World Health Assembly also set a goal of global leprosy elimination (defined as incidence less than 1 case per 10,000 population) by the year 2000.

Reference

1. CDC. International Task Force for Disease Eradication. MMWR 1990;39:209–12,217.

FIGURE I. Notifiable disease reports, comparison of 4-week totals ending January 18, 1992, with historical data — United States



*Ratio of current 4-week total to the mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary — cases of specified notifiable diseases, United States, cumulative, week ending January 18, 1992 (3rd Week)

	Cum. 1992		Cum. 1992
AIDS	2,515	Measles: imported	-
Anthrax	-	indigenous	4
Botulism: Foodborne	-	Plague	-
Infant	-	Poliomyelitis, Paralytic*	-
Other	-	Psittacosis	2
Brucellosis	1	Rabies, human	-
Cholera	-	Syphilis, primary & secondary	1,547
Congenital rubella syndrome	-	Syphilis, congenital, age < 1 year	-
Diphtheria	-	Tetanus	-
Encephalitis, post-infectious	2	Toxic shock syndrome	8
Gonorrhea	25,451	Trichinosis	1
Haemophilus influenzae (invasive disease)	64	Tuberculosis	861
Hansen Disease	-	Tularemia	5
Leptospirosis	1	Typhoid fever	5
Lyme Disease	86	Typhus fever, tickborne (RMSF)	3

*Nine suspected cases of poliomyelitis have been reported in 1991; 4 of the 8 suspected cases in 1990 were confirmed, and all were vaccine associated.

TABLE II. Cases of selected notifiable diseases, United States, weeks ending January 18, 1992, and January 19, 1991 (3rd Week)

Reporting Area	AIDS	Aseptic Menin-gitis	Encephalitis: Primary	Encephalitis: Post-in-fectious	Gonorrhea		Hepatitis (Viral), by type: A	Hepatitis (Viral), by type: B	Hepatitis (Viral), by type: NA,NB	Hepatitis (Viral), by type: Unspeci-fied	Legionel-losis	Lyme Disease
	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1991	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992
UNITED STATES	2,515	222	19	2	25,451	26,831	531	354	65	14	37	85
NEW ENGLAND	13	43	-	-	552	1,228	27	38	2	4	7	15
Maine	6	-	-	-	1	4	5	-	-	-	2	-
N.H.	6	1	-	-	-	19	4	5	-	-	1	2
Vt.	-	1	-	-	1	4	-	1	1	-	-	-
Mass.	-	7	-	-	237	387	12	27	1	4	3	1
R.I.	-	34	-	-	42	42	5	5	-	-	1	12
Conn.	1	-	-	-	271	772	1	-	-	-	-	-
MID. ATLANTIC	551	9	-	-	951	3,022	24	33	3	-	2	44
Upstate N.Y.	56	-	-	-	-	465	-	-	-	-	-	-
N.Y. City	364	4	-	-	-	483	4	1	-	-	1	-
N.J.	98	-	-	-	350	575	1	4	2	-	-	3
Pa.	33	5	-	-	601	1,499	19	28	1	-	1	41
E.N. CENTRAL	227	41	5	-	5,220	4,028	67	63	7	2	14	8
Ohio	34	13	2	-	2,060	-	36	13	5	-	11	8
Ind.	31	5	-	-	446	681	20	17	-	1	-	-
Ill.	142	-	-	-	2,245	1,380	-	-	-	-	-	-
Mich.	11	23	3	-	427	1,546	8	29	1	1	3	-
Wis.	9	-	-	-	42	421	3	4	1	-	-	-
W.N. CENTRAL	122	15	1	-	1,302	1,201	52	5	-	-	1	1
Minn.	15	1	-	-	140	155	1	-	-	-	-	-
Iowa	8	6	-	-	53	104	1	2	-	-	1	1
Mo.	87	-	-	-	769	621	-	-	-	-	-	-
N. Dak.	-	1	-	-	-	2	1	-	-	-	-	-
S. Dak.	-	-	-	-	6	15	33	-	-	-	-	-
Nebr.	4	-	-	-	33	153	6	-	-	-	-	-
Kans.	8	7	1	-	301	151	10	3	-	-	-	-
S. ATLANTIC	591	41	5	1	10,185	9,243	22	56	9	2	6	8
Del.	7	3	2	-	82	86	-	5	-	-	-	2
Md.	98	13	-	-	805	1,071	5	18	2	2	1	1
D.C.	30	-	-	-	443	636	1	2	-	-	-	-
Va.	4	7	1	-	1,138	498	3	3	-	-	1	5
W. Va.	7	-	-	-	56	78	1	1	-	-	-	-
N.C.	50	10	2	-	1,220	1,785	2	13	4	-	1	-
S.C.	26	1	-	-	741	706	5	3	-	-	3	-
Ga.	1	4	-	-	4,189	2,495	3	2	-	-	-	-
Fla.	368	3	-	1	1,511	1,888	2	9	3	-	-	-
E.S. CENTRAL	99	22	-	-	1,507	2,590	9	28	20	-	2	-
Ky.	2	16	-	-	241	301	3	4	-	-	1	-
Tenn.	13	1	-	-	242	813	4	16	16	-	1	-
Ala.	84	5	-	-	400	929	2	8	4	-	-	-
Miss.	-	-	-	-	624	547	-	-	-	-	-	-
W.S. CENTRAL	231	4	-	-	2,439	2,024	23	19	2	1	-	2
Ark.	13	4	-	-	1	315	6	8	-	-	-	1
La.	24	-	-	-	474	425	-	-	-	-	-	-
Okla.	41	-	-	-	208	325	17	11	2	1	-	1
Tex.	153	-	-	-	1,756	959	-	-	-	-	-	-
MOUNTAIN	92	6	-	-	588	717	93	20	6	2	2	-
Mont.	1	-	-	-	6	4	4	2	-	-	-	-
Idaho	-	-	-	-	4	4	1	3	-	-	-	-
Wyo.	-	-	-	-	3	4	-	1	3	-	-	-
Colo.	39	1	-	-	155	183	9	4	2	2	-	-
N. Mex.	9	1	-	-	60	50	-	-	-	-	-	-
Ariz.	21	4	-	-	218	325	73	7	1	-	2	-
Utah	1	-	-	-	5	25	1	-	-	-	-	-
Nev.	21	-	-	-	137	122	5	3	-	-	-	-
PACIFIC	589	41	8	1	2,707	2,778	214	92	16	3	3	7
Wash.	2	-	-	-	190	344	7	14	3	-	3	-
Oreg.	-	-	-	-	66	122	11	11	3	-	-	-
Calif.	577	39	7	1	2,403	2,237	191	67	10	3	-	7
Alaska	-	1	1	-	41	48	-	-	-	-	-	-
Hawaii	10	1	-	-	7	27	5	-	-	-	-	-
Guam	-	-	-	-	12	-	1	-	-	2	-	-
P.R.	-	1	-	-	1	-	-	1	-	-	-	-
V.I.	-	-	-	-	3	[illegible]	-	1	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-	-	-	-
C.N.M.I.	-	-	-	-	-	2	-	-	-	-	-	-

N: Not notifiable U: Unavailable C.N.M.I.: Commonwealth of the Northern Mariana Islands

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending January 18, 1992, and January 19, 1991 (3rd Week)

Reporting Area	Malaria	Measles (Rubeola)					Menin-gococcal Infections	Mumps		Pertussis			Rubella		
		Indigenous		Imported*		Total									
	Cum. 1992	1992	Cum. 1992	1992	Cum. 1992	Cum. 1991	Cum. 1992	1992	Cum. 1992	1992	Cum. 1992	Cum. 1991	1992	Cum. 1992	Cum. 1991
UNITED STATES	18	3	4	-	-	167	114	21	65	7	19	103	6	10	7
NEW ENGLAND	1	-	-	-	-	-	8	-	-	-	-	7	4	4	-
Maine	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-
N.H.	-	-	-	-	-	-	-	-	-	-	-	6	-	-	-
Vt.	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-
Mass.	1	-	-	-	-	-	3	-	-	-	-	-	-	-	-
R.I.	-	-	-	-	-	-	-	-	-	-	-	-	4	4	-
Conn.	-	-	-	-	-	-	3	-	-	-	-	-	-	-	-
MID. ATLANTIC	2	-	-	-	-	100	4	-	-	-	-	20	-	-	-
Upstate N.Y.	-	-	-	-	-	-	-	-	-	-	-	5	-	-	-
N.Y. City	-	-	-	-	-	6	2	-	-	-	-	-	-	-	-
N.J.	1	-	-	-	-	27	-	-	-	-	-	1	-	-	-
Pa.	1	-	-	-	-	67	2	-	-	-	-	14	-	-	-
E.N. CENTRAL	1	-	-	-	-	3	23	-	8	1	5	30	-	-	1
Ohio	-	-	-	-	-	-	1	-	5	-	-	5	-	-	-
Ind.	-	-	-	-	-	-	5	-	-	-	4	9	-	-	1
Ill.	-	-	-	-	-	1	9	-	1	-	-	12	-	-	-
Mich.	-	-	-	-	-	1	8	-	2	1	1	2	-	-	-
Wis.	1	-	-	-	-	1	-	-	-	-	-	2	-	-	-
W.N. CENTRAL	1	-	-	-	-	-	9	1	1	-	-	12	-	-	2
Minn.	-	-	-	-	-	-	1	-	-	-	-	7	-	-	1
Iowa	1	-	-	-	-	-	-	1	1	-	-	2	-	-	-
Mo.	-	-	-	-	-	-	-	-	-	-	-	1	-	-	1
N. Dak.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-
Nebr.	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-
Kans.	-	-	-	-	-	-	8	-	-	-	-	-	-	-	-
S. ATLANTIC	4	-	-	-	-	2	22	10	26	5	6	1	-	-	-
Del.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Md.	2	-	-	-	-	-	2	3	9	5	6	-	-	-	-
D.C.	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Va.	-	-	-	-	-	-	3	-	3	-	-	1	-	-	-
W. Va.	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-
N.C.	-	-	-	-	-	-	6	-	-	-	-	-	-	-	-
S.C.	-	-	-	-	-	-	3	1	3	-	-	-	-	-	-
Ga.	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-
Fla.	1	-	-	-	-	2	4	6	11	-	-	-	-	-	-
E.S. CENTRAL	-	3	3	-	-	-	11	-	3	-	3	2	-	-	-
Ky.	-	3	3	-	-	-	7	-	-	-	-	-	-	-	-
Tenn.	-	-	-	-	-	-	1	-	-	-	-	1	-	-	-
Ala.	-	-	-	-	-	-	3	-	3	-	3	1	-	-	-
Miss.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
W.S. CENTRAL	-	-	-	-	-	4	8	1	2	-	-	5	-	-	-
Ark.	-	-	-	-	-	4	3	1	2	-	-	-	-	-	-
La.	-	-	-	-	-	-	-	-	-	-	-	5	-	-	-
Okla.	-	-	-	-	-	-	5	-	-	-	-	-	-	-	-
Tex.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
MOUNTAIN	3	-	-	-	-	8	7	2	7	-	1	9	-	-	1
Mont.	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-
Idaho	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-
Wyo.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Colo.	2	-	-	-	-	-	1	2	2	-	1	3	-	-	-
N. Mex.	1	-	-	-	-	2	-	N	N	-	-	1	-	-	-
Ariz.	-	-	-	-	-	1	-	-	3	-	-	5	-	-	-
Utah	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Nev.	-	-	-	-	-	5	3	-	2	-	-	-	-	-	1
PACIFIC	6	-	1	-	-	50	22	7	18	1	4	17	2	6	3
Wash.	2	-	-	-	-	-	5	1	2	-	-	-	-	-	-
Oreg.	1	-	1	-	-	-	6	N	N	1	1	1	-	-	-
Calif.	1	-	-	-	-	50	8	6	16	-	3	9	2	4	3
Alaska	-	-	-	-	-	-	1	-	-	-	-	1	-	-	-
Hawaii	2	-	-	-	-	-	2	-	-	-	-	6	-	2	-
Guam	-	U	-	U	-	-	-	U	1	U	-	-	U	-	-
P.R.	-	U	-	U	-	-	-	U	-	U	1	-	U	-	-
V.I.	-	-	-	-	-	-	-	1	2	-	-	-	-	-	-
Amer. Samoa	-	U	-	U	-	-	-	U	-	U	-	-	U	-	-
C.N.M.I.	-	U	-	U	-	-	-	U	-	U	-	-	U	-	-

*For measles only, imported cases includes both out-of-state and international importations.

N: Not notifiable U: Unavailable †International §Out-of-state

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending January 18, 1992, and January 19, 1991 (3rd Week)

Reporting Area	Syphilis (Primary & Secondary)		Toxic-shock Syndrome	Tuberculosis		Tula-remia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies, Animal
	Cum. 1992	Cum. 1991	Cum. 1992	Cum. 1992	Cum. 1991	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992
UNITED STATES	1,547	2,009	8	861	872	5	5	3	235
NEW ENGLAND	31	64	2	96	26	-	-	-	22
Maine	-	-	-	16	16	-	-	-	-
N.H.	-	-	1	-	-	-	-	-	-
Vt.	-	1	-	-	-	-	-	-	-
Mass.	15	34	1	80	-	-	-	-	-
R.I.	2	2	-	-	2	-	-	-	-
Conn.	14	27	-	-	8	-	-	-	22
MID. ATLANTIC	132	492	1	147	170	-	1	-	57
Upstate N.Y.	-	17	-	-	7	-	-	-	-
N.Y. City	65	245	-	126	127	-	-	-	-
N.J.	19	74	-	4	25	-	1	-	40
Pa.	48	156	1	17	11	-	-	-	17
E.N. CENTRAL	282	202	1	46	95	-	1	-	7
Ohio	44	8	1	11	38	-	1	-	-
Ind.	19	6	-	5	1	-	-	-	-
Ill.	149	131	-	23	52	-	-	-	1
Mich.	62	19	-	4	-	-	-	-	-
Wis.	8	38	-	3	4	-	-	-	6
W.N. CENTRAL	40	30	1	10	11	-	-	-	34
Minn.	-	4	1	5	-	-	-	-	11
Iowa	-	2	-	1	6	-	-	-	7
Mo.	39	24	-	4	-	-	-	-	-
N. Dak.	-	-	-	-	3	-	-	-	5
S. Dak.	-	-	-	-	-	-	-	-	-
Nebr.	1	-	-	-	-	-	-	-	-
Kans.	-	-	-	-	2	-	-	-	11
S. ATLANTIC	609	597	1	99	60	2	1	-	69
Del.	6	6	-	1	2	-	-	-	10
Md.	198	55	-	28	3	2	-	-	27
D.C.	55	42	-	5	5	-	1	-	3
Va.	46	35	-	-	7	-	-	-	7
W. Va.	3	1	-	5	6	-	-	-	2
N.C.	87	69	1	6	12	-	-	-	-
S.C.	44	78	-	13	14	-	-	-	5
Ga.	103	138	-	-	8	-	-	-	15
Fla.	67	173	-	41	3	-	-	-	-
E.S. CENTRAL	148	122	-	27	45	1	-	-	1
Ky.	6	5	-	9	7	1	-	-	-
Tenn.	18	25	-	-	-	-	-	-	-
Ala.	46	51	-	14	27	-	-	-	1
Miss.	78	41	-	4	11	-	-	-	-
W.S. CENTRAL	219	227	-	-	26	2	-	3	26
Ark.	-	9	-	-	5	1	-	2	3
La.	79	86	-	-	-	-	-	-	-
Okla.	8	11	-	-	-	1	-	1	23
Tex.	132	121	-	-	21	-	-	-	-
MOUNTAIN	33	50	2	4	39	-	-	-	5
Mont.	-	-	-	-	-	-	-	-	1
Idaho	1	-	-	-	-	-	-	-	-
Wyo.	-	1	-	-	-	-	-	-	4
Colo.	2	8	1	-	6	-	-	-	-
N. Mex.	2	-	-	-	-	-	-	-	-
Ariz.	7	41	1	-	22	-	-	-	-
Utah	-	-	-	-	10	-	-	-	-
Nev.	21	-	-	4	1	-	-	-	-
PACIFIC	53	225	-	432	400	-	2	-	14
Wash.	-	12	-	16	10	-	-	-	-
Oreg.	3	3	-	5	6	-	-	-	-
Calif.	50	209	-	407	373	-	2	-	14
Alaska	-	1	-	-	2	-	-	-	-
Hawaii	-	-	-	4	9	-	-	-	-
Guam	1	-	-	-	-	-	-	-	-
P.R.	5	-	-	-	-	-	-	-	-
V.I.	1	-	-	1	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-
C.N.M.I.	-	-	-	-	4	-	-	-	-

U: Unavailable

TABLE III. Deaths in 121 U.S. cities,* week ending January 18, 1992 (3rd Week)

Reporting Area	All Causes, By Age (Years)						P&I†
	All Ages	≥65	45-64	25-44	1-24	<1	Total
NEW ENGLAND	698	528	95	47	13	15	91
Boston, Mass.	213	139	40	19	7	8	31
Bridgeport, Conn.	U	U	U	U	U	U	U
Cambridge, Mass.	24	18	2	4	-	-	4
Fall River, Mass.	35	34	1	-	-	-	3
Hartford, Conn.	60	43	11	3	1	2	3
Lowell, Mass.	45	38	5	2	-	-	6
Lynn, Mass.	27	23	3	1	-	-	1
New Bedford, Mass.	25	19	3	2	-	1	3
New Haven, Conn.	50	40	4	3	2	1	7
Providence, R.I.	49	39	7	2	1	-	3
Somerville, Mass.	10	9	-	-	1	-	-
Springfield, Mass.	66	48	9	7	1	1	8
Waterbury, Conn.	34	29	2	3	-	-	5
Worcester, Mass.	60	49	8	1	-	2	17
MID. ATLANTIC	2,835	1,875	512	287	77	83	200
Albany, N.Y.	73	55	11	2	1	4	6
Allentown, Pa.	34	28	5	1	-	-	1
Buffalo, N.Y.	99	67	20	8	2	2	3
Camden, N.J.	45	28	9	1	2	5	6
Elizabeth, N.J.	37	26	7	2	2	-	2
Erie, Pa.§	38	30	6	2	-	-	3
Jersey City, N.J.	55	37	9	7	1	1	7
New York City, N.Y.	1,184	754	220	149	33	28	57
Newark, N.J.	75	30	18	18	5	4	13
Paterson, N.J.	37	22	5	6	-	4	1
Philadelphia, Pa.	606	389	114	55	23	25	33
Pittsburgh, Pa.§	71	49	10	8	1	2	6
Reading, Pa.	33	27	5	1	-	-	15
Rochester, N.Y.	147	111	19	10	4	3	10
Schenectady, N.Y.	36	25	6	4	-	1	1
Scranton, Pa.§	43	36	6	-	1	-	4
Syracuse, N.Y.	122	88	22	7	1	4	18
Trenton, N.J.	56	38	13	4	1	-	10
Utica, N.Y.	16	13	2	1	-	-	1
Yonkers, N.Y.	28	22	5	1	-	-	3
E.N. CENTRAL	2,463	1,544	469	226	158	66	193
Akron, Ohio	92	74	12	3	1	2	14
Canton, Ohio	40	29	10	1	-	-	6
Chicago, Ill.	509	184	114	107	85	19	25
Cincinnati, Ohio	173	125	34	8	2	4	22
Cleveland, Ohio	160	91	39	12	8	10	3
Columbus, Ohio	U	U	U	U	U	U	U
Dayton, Ohio	183	140	29	9	3	2	11
Detroit, Mich.	201	106	42	25	15	13	10
Evansville, Ind.	50	41	7	2	-	-	5
Fort Wayne, Ind.	80	60	10	3	4	3	9
Gary, Ind.	30	12	10	5	1	2	1
Grand Rapids, Mich.	65	54	7	2	1	1	12
Indianapolis, Ind.	217	149	40	18	7	3	18
Madison, Wis.	48	32	11	4	-	1	7
Milwaukee, Wis.	180	137	30	10	3	-	16
Peoria, Ill.	56	36	15	2	1	2	7
Rockford, Ill.	51	38	11	2	-	-	6
South Bend, Ind.	49	42	4	3	-	-	2
Toledo, Ohio	209	137	35	9	25	3	15
Youngstown, Ohio	70	57	9	1	2	1	4
W.N. CENTRAL	971	697	159	64	24	27	68
Des Moines, Iowa	105	80	15	5	3	2	7
Duluth, Minn.	31	22	5	1	1	2	2
Kansas City, Kans.	30	23	5	1	1	-	3
Kansas City, Mo.	140	94	29	13	2	2	6
Lincoln, Nebr.	45	33	9	1	1	1	3
Minneapolis, Minn.	170	118	32	16	4	-	19
Omaha, Nebr.	142	104	17	10	4	7	13
St. Louis, Mo.	134	96	13	9	7	9	-
St. Paul, Minn.	90	63	18	4	1	4	11
Wichita, Kans.	84	64	16	4	-	-	4
S. ATLANTIC	1,441	914	312	129	51	33	76
Atlanta, Ga.	251	139	62	35	11	4	12
Baltimore, Md.	324	195	83	26	14	6	26
Charlotte, N.C.	104	65	17	14	7	1	5
Jacksonville, Fla.	144	96	32	6	4	5	-
Miami, Fla.	97	62	20	13	-	1	2
Norfolk, Va.	77	50	15	6	1	5	3
Richmond, Va.	80	52	17	5	4	2	4
Savannah, Ga.	65	35	17	9	2	2	1
St. Petersburg, Fla.	83	64	9	3	3	4	-
Tampa, Fla.	174	123	36	9	4	2	20
Washington, D.C.	U	U	U	U	U	U	U
Wilmington, Del.	42	33	4	3	1	1	3
E.S. CENTRAL	1,118	754	208	85	41	30	80
Birmingham, Ala.	200	123	42	15	13	7	4
Chattanooga, Tenn.	89	70	12	4	3	-	10
Knoxville, Tenn.	122	89	22	6	1	4	16
Louisville, Ky.	117	76	25	11	1	4	11
Memphis, Tenn.	248	166	44	19	8	11	14
Mobile, Ala.	92	58	22	8	3	1	5
Montgomery, Ala.	100	70	17	6	6	1	7
Nashville, Tenn.	150	102	24	16	6	2	13
W.S. CENTRAL	1,786	1,124	383	164	70	45	125
Austin, Tex.	58	36	11	7	3	1	6
Baton Rouge, La.	77	50	14	11	1	1	2
Corpus Christi, Tex.	53	44	8	-	-	1	4
Dallas, Tex.	171	89	44	18	11	9	6
El Paso, Tex.	118	87	15	7	7	2	7
Ft. Worth, Tex.	126	85	17	15	6	3	6
Houston, Tex.	457	264	114	57	14	8	42
Little Rock, Ark.	96	64	22	1	5	4	6
New Orleans, La.	240	147	45	28	11	9	-
San Antonio, Tex.	211	126	59	15	6	5	23
Shreveport, La.	71	50	14	2	4	1	8
Tulsa, Okla.	108	82	20	3	2	1	15
MOUNTAIN	1,004	683	176	86	29	30	82
Albuquerque, N.M.	102	65	20	12	4	1	8
Colo. Springs, Colo.	52	38	8	4	1	1	4
Denver, Colo.	135	100	21	11	-	3	28
Las Vegas, Nev.	225	148	51	15	7	4	14
Ogden, Utah	33	22	2	7	1	1	3
Phoenix, Ariz.	191	120	38	19	7	7	8
Pueblo, Colo.	34	28	5	1	-	-	4
Salt Lake City, Utah	81	58	5	6	3	9	9
Tucson, Ariz.	151	104	26	11	6	4	4
PACIFIC	1,652	1,147	283	132	52	33	188
Berkeley, Calif.	21	12	7	2	-	-	1
Fresno, Calif.	184	142	23	9	4	6	33
Glendale, Calif.	U	U	U	U	U	U	U
Honolulu, Hawaii	88	59	22	3	4	-	7
Long Beach, Calif.	113	82	19	9	2	1	22
Los Angeles, Calif.	U	U	U	U	U	U	U
Pasadena, Calif.	42	30	7	4	1	-	8
Portland, Oreg.	92	75	8	6	1	2	4
Sacramento, Calif.	191	135	35	-	17	4	22
San Diego, Calif.	130	83	23	17	4	1	20
San Francisco, Calif.	197	103	43	40	6	2	10
San Jose, Calif.	206	154	28	16	4	4	32
Santa Cruz, Calif.	57	47	5	3	-	2	9
Seattle, Wash.	170	117	27	14	5	7	5
Spokane, Wash.	57	47	8	1	-	1	8
Tacoma, Wash.	104	61	28	8	4	3	7
TOTAL	13,968¶	9,266	2,597	1,220	515	362	1,103

*Mortality data in this table are voluntarily reported from 121 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

†Pneumonia and influenza.

§Because of changes in reporting methods in these 3 Pennsylvania cities, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶Total includes unknown ages.

U: Unavailable

FIGURE II. Acquired immunodeficiency syndrome cases, by 4-week period of report – United States, 1984–1991

*Change in case definition.

FIGURE III. Tuberculosis cases, by 4-week period of report – United States, 1984–1991

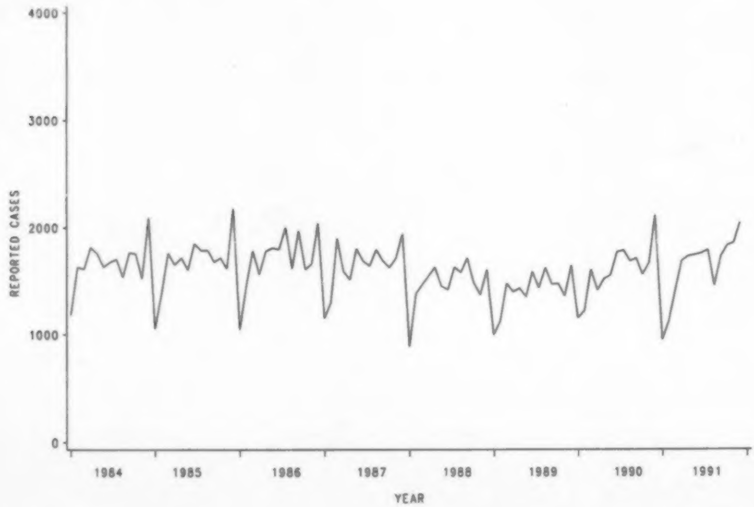


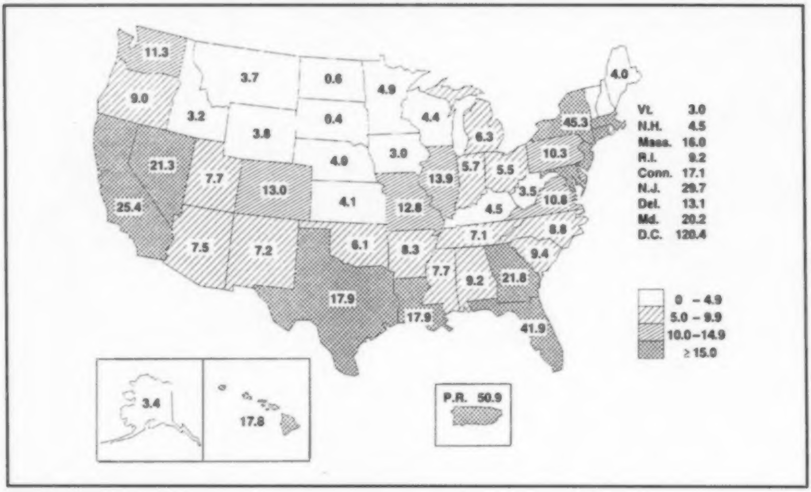
FIGURE IV. Gonorrhea cases, by 4-week period of report — United States, 1984–1991

FIGURE V. Syphilis cases, by 4-week period of report — United States, 1984–1991

Quarterly AIDS Map

The following map provides information on the reported number of acquired immunodeficiency syndrome (AIDS) cases per 100,000 population by state of residence from January through December 1991. The map appears quarterly in *MMWR*. More detailed information on AIDS cases is provided in the monthly *HIV/AIDS Surveillance Report*, single copies of which are available free from the National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone (800) 458-5231.

AIDS cases per 100,000 population – United States, January–December 1991



The *Morbidity and Mortality Weekly Report* (*MMWR*) Series is prepared by the Centers for Disease Control and is available on a paid subscription basis from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone (202) 783-3238.

The data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the succeeding Friday. Inquiries about the *MMWR* Series, including material to be considered for publication, should be directed to: Editor, *MMWR* Series, Mailstop C-08, Centers for Disease Control, Atlanta, GA 30333; telephone (404) 332-4555.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control
Atlanta, Georgia 30333

Official Business
Penalty for Private Use $300

HHS Publication No. (CDC) 92-8017